REPORT BY THE

# AUDITOR GENERAL

OF CALIFORNIA

## PRE-ADMISSION SCREENING REDUCES THE COST OF PROVIDING LONG-TERM CARE TO ELDERLY MEDI-CAL BENEFICIARIES AND PROMOTES INDEPENDENT LIVING

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TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

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April 10, 1984

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Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning pre-admission screening of Medi-Cal beneficiaries living in the community who request admission to nursing homes. Only two of the Department of Health Services' twelve Medi-Cal offices have implemented this procedure. Yet, we have found that pre-admission screening reduces the State's expenditures for long-term care and that it promotes independent living for elderly Medi-Cal beneficiaries through increased reliance on community-based long-term care services.

Respectfully submitted,

Thomas W. Hayes

THOMAS W. HAYES
Auditor General

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## SUMMARY

The Department of Health Services (department) could reduce the cost of long-term care for elderly Medi-Cal beneficiaries by implementing pre-admission screening of requests for admission to nursing homes. Pre-admission screening, a procedure for evaluating admissions to nursing homes while beneficiaries are still living in the community, emphasizes providing long-term care in a community setting. Community-based long-term care services are more appropriate for some Medi-Cal beneficiaries and are also less costly to the State. Although the Legislature has emphasized reducing the use of inappropriate nursing home care, the department currently uses pre-admission screening in only two Medi-Cal field offices. Our reviews of records in the San Jose field office determined that in this office alone pre-admission screening saved the State approximately $45,000 in public assistance funds in fiscal year 1982-83. Moreover, we estimate that pre-admission screening of all requests for nursing home care for beneficiaries living in the community served by this office alone would have saved the State $113,000 in fiscal year 1982-83.

### Advantages of Pre-Admission Screening

Pre-admission screening has several advantages over the post-admission review process currently used by the department. First, pre-admission screening affords more opportunity than that provided by post-admission review for keeping elderly Medi-Cal beneficiaries out of nursing homes. Studies show that self-care skills of elderly persons may deteriorate after they are admitted to nursing homes. Being discharged from a nursing home by the post-admission review process may also cause problems for beneficiaries. For example, elderly persons admitted to nursing homes may no longer have homes to which they may return.

In addition, pre-admission screening, as implemented in other states, uses multidisciplinary teams, including medical personnel and social workers, who conduct comprehensive assessments of a beneficiary's physical, psychological, and social condition. These teams develop care plans that emphasize the use of community-based long-term care services.

Not only do community-based services permit beneficiaries to remain in the community, but these services are also typically less expensive than nursing home care. For example, pre-admission screening of beneficiaries in Massachusetts produced a "cost avoidance" of $1.2 million in fiscal year 1982-83. This figure takes into account costs associated with community-based long-term care services.

Pre-Admission Screening Reduces Medi-Cal Costs

Two of the department's 12 Medi-Cal field offices have implemented pre-admission screening. Since January 1982, the San Jose field office has implemented pre-admission screening of requests to enter nursing homes; these requests were voluntarily referred to the office by the homes. During fiscal year 1982-83, the San Jose field office diverted to community-based long-term care services 58 (21.2 percent) of the 273 beneficiaries screened. The beneficiaries diverted were all eligible for nursing home care. We estimate that the net public assistance savings for 37 of these beneficiaries for whom we could compare costs was $73,000 during fiscal year 1982-83, with the State's share $45,400. We also estimate that if the San Jose field office had implemented pre-admission screening of all requests for admission to nursing homes from beneficiaries living in the community, this office alone could have saved the State approximately $113,000 in fiscal year 1982-83.

## Department Reasons for Not Implementing Pre-Admission Screening Are Inadequate

The chief of the department's Field Services Branch, which operates the State's Medi-Cal field offices, presented the following justifications for not implementing pre-admission screening in all field offices: the staffing in field offices is not sufficient to implement pre-admission screening, the supply of community-based long-term care services is insufficient, and the department has tested pre-admission screening and found it unsuccessful. In addition, field office staff stated that the department's current on-site review process prevents inappropriate placement.

We have evaluated all these reasons. Based on our reviews of records and on visits to all Medi-Cal offices throughout the State, we concluded that although some of the problems cited by the Field Services Branch may limit the effectiveness of pre-admission screening in some offices, the problems do not preclude testing the program in all offices.

## Recommendations

The Department of Health Services should require all Medi-Cal field offices to implement pre-admission screening of all requests for nursing home care received from beneficiaries residing in the community. The department should also require that nursing homes refer to the Medi-Cal field offices all admission requests from these Medi-Cal beneficiaries. After one year, the department should evaluate pre-admission screening in each field office and retain the program in offices where it is cost-effective. The department should request more staff only for offices that prove they cannot implement pre-admission screening with current staff. Finally, field office staff should document cases in which lack of community-based long-term care services requires placing beneficiaries at a higher level of care than is appropriate. The department should report the shortage of

community-based long-term care services in the State to the entity to be designated by the Legislature as responsible for planning community-based long-term care.

# INTRODUCTION

Elderly persons who lose their ability to care for themselves may need some type of long-term care services. These services, which address the medical, social, and personal needs of the individuals, include preventive, diagnostic, therapeutic, rehabilitative, supportive, and maintenance services. In California, the state government and the federal government subsidize long-term care services through the California Medical Assistance Program, the In-Home Supportive Services Program, and the Supplemental Security Income/State Supplementary Program.

The Medical Assistance Program (Medi-Cal), which provides health care to persons with low income, is administered by the Department of Health Services. In fiscal year 1982-83, Medi-Cal spent approximately $720 million to provide long-term care services to approximately 780,000 beneficiaries. The State's share of these expenditures was $403 million.

The Field Services Branch of the Department of Health Services' Medi-Cal Division is responsible for controlling the utilization of Medi-Cal services. The Field Services Branch operates 12 field offices throughout the State. These field offices employ nurse consultants, physicians, and social services consultants to determine if the health care services that beneficiaries request are appropriate for the medical

condition of each beneficiary. Medi-Cal pays for long-term care provided by nursing homes. It also pays for some community-based long-term care services.

## Nursing Homes

Medi-Cal pays for long-term care at skilled nursing facilities and at intermediate care facilities, collectively referred to in this report as "nursing homes." Medi-Cal authorizes care at skilled nursing facilities for beneficiaries whose medical conditions are not severe enough to require hospitalization, but who do require continuous availability of skilled nursing care. Care at intermediate care facilities is authorized for Medi-Cal beneficiaries who require protective and supportive care; these beneficiaries must require less than continuous skilled assistance by a registered nurse and must have no illness, injury, or disability that warrants hospitalization.

Medi-Cal nurse consultants presently visit approximately 90 percent of the nursing homes in California serving Medi-Cal beneficiaries to conduct on-site reviews of the medical condition of beneficiaries admitted to the homes. In general, nurse consultants conduct these on-site reviews within 30 days after admission of the beneficiaries. During the reviews, the nurse consultants determine the appropriateness of the requested services by interviewing the beneficiaries and by reviewing the requests for treatment and the medical records.

## Community-Based Long-Term Care Services

According to a study conducted in 1982 by the U.S. Department of Health and Human Services' Health Care Financing Administration, nearly all persons seeking admission to nursing homes need some level of long-term medical and nonmedical assistance. However, many of these persons can receive the needed services without entering a nursing home if they have access to community-based long-term care services and have family support.

Family support refers to assistance that an elderly person's family members can provide. Community-based long-term care services consist of a variety of programs that provide health care and assistance with personal maintenance or domestic chores. Residential care, home health care, adult day health care, and in-home supportive services are all considered community-based long-term care services. These two sources of assistance--family support and community-based services--can enable elderly persons to reside either in their own homes, in the homes of family members or friends, or in residential care facilities that provide food, lodging, and general assistance in activities of daily living, such as dressing, eating, bathing, and taking medications.

One of the services that Medi-Cal provides for low-income elderly persons who remain in the community is home health care. To qualify for home health care, beneficiaries must require skilled services to prevent further disability or to promote improvement of their medical

condition. These services include physical therapy, occupational therapy, and speech therapy.

In some parts of the State, elderly Medi-Cal beneficiaries with physical or mental impairments can receive adult day health care. To help the beneficiaries maintain or restore their ability to care for themselves, adult day health care centers provide organized day programs of therapeutic, social, and health activities or services.

County welfare departments administer another community-based long-term care service, the In-Home Supportive Services (IHSS) Program. By providing care to eligible elderly in their homes, in-home supportive services enable them to remain out of nursing homes. Services available under this program include assistance in nonmedical personal care, such as feeding, grooming, and ambulation, and assistance in domestic chores, including housecleaning, preparing meals, and shopping for food. Expenditures for the IHSS Program in fiscal year 1982-83 amounted to $271 million, which included $117 million in state monies.

In addition to receiving health-related long-term care services and in-home supportive services, low-income elderly persons are eligible for cash grants for basic needs and living expenses through the Supplemental Security Income/State Supplementary Program (SSI/SSP). Elderly recipients in California received approximately $698 million in SSI/SSP funds in fiscal year 1982-83. This amount included approximately $446 million from the State's General Fund. For elderly recipients who

can live independently in the community, the SSI/SSP plays a major role in preventing or delaying unnecessary admission to nursing homes by providing the recipients with sufficient income to meet their basic needs. Elderly recipients who can no longer live independently in their own homes may use their SSI/SSP payments to cover the cost of living in residential care facilities.

## Pre-Admission Screening

As part of their service to persons on Medicaid, some states have implemented a program known as pre-admission screening, which emphasizes the use of community-based long-term care services whenever possible. Pre-admission screening enables staff to evaluate requests for admission of Medicaid beneficiaries to nursing homes while the beneficiaries are still living in the community. When pre-admission screening determines that a beneficiary does not require admission to a nursing home, the beneficiary can be "diverted" to community-based long-term care services.

The Department of Health Services currently grants Medi-Cal field offices the option of implementing pre-admission screening. At present, only 2 of the State's 12 Medi-Cal field offices--the San Jose office and the San Diego office--exercise this option. The Oakland and Los Angeles field offices tested pre-admission screening in the past. Following the tests, both offices discontinued pre-admission screening.

## SCOPE AND METHODOLOGY

The objective of this audit was to determine if all Medi-Cal field offices should implement pre-admission screening for Medi-Cal beneficiaries living in the community who request admission to nursing homes. To accomplish our objective, we reviewed the method by which the Department of Health Services (department) controls admissions to nursing homes and the extent to which the department has implemented pre-admission screening. We also evaluated the effectiveness of pre-admission screening in diverting beneficiaries to community-based long-term care services. Finally, we estimated the cost savings associated with pre-admission screening.

To determine the status of pre-admission screening in California, we examined the department's policies and procedures on regulating admissions to nursing homes. We interviewed the department's management and the staff in each of the 12 Medi-Cal field offices to identify offices that had implemented pre-admission screening and to determine why the other offices had not initiated it.

To determine the rate at which pre-admission screening can divert beneficiaries eligible for nursing home care to community-based long-term care services, we examined the pre-admission screening program at the San Jose Medi-Cal field office. At this office we compiled a roster of beneficiaries who appeared to have been diverted to community-based long-term care services during fiscal year 1982-83. By

reviewing files and discussing the cases with the social services consultant in the San Jose office, we identified the beneficiaries on this roster who were also eligible for care in a skilled nursing facility at the time they were diverted to community-based long-term care services.

Our final step was to determine if pre-admission screening saves public funds. We first calculated the cost of providing the community-based long-term care services to the beneficiaries whom the San Jose field office had diverted to community-based services. We obtained data on Medi-Cal expenditures from the department's Center for Health Statistics, data on IHSS expenditures from county welfare departments that provided the services and from the Department of Social Services, and data on SSI/SSP expenditures from the Social Security Administration. These expenditures were for fiscal year 1982-83.

Using data supplied by the Center for Health Statistics, we calculated the average monthly cost to the state government and the federal government for a Medi-Cal beneficiary in a skilled nursing facility during fiscal year 1982-83. We then compared the cost of community-based long-term care services each beneficiary received during fiscal year 1982-83 with the amount that would have been required to provide each beneficiary care in a skilled nursing facility during the same period.

In this report, we consider pre-admission screening only for Medi-Cal beneficiaries living in the community in their own homes, in the homes of relatives or friends, or in residential care facilities at the time they request admission to a nursing home. We did not consider pre-admission screening for beneficiaries who are admitted to acute care hospitals prior to requesting admission to nursing homes. Since beneficiaries admitted to acute care hospitals are more likely to require care in a nursing home, they are less likely to be diverted through pre-admission screening.

## AUDIT RESULTS

### THE DEPARTMENT OF HEALTH SERVICES CAN REDUCE MEDI-CAL EXPENDITURES FOR LONG-TERM CARE BY IMPLEMENTING PRE-ADMISSION SCREENING

Pre-admission screening of requests for nursing home care is an effective method for ensuring that Medi-Cal beneficiaries receive the lowest appropriate level of long-term care. Eighteen states now use pre-admission screening. Comprehensive pre-admission screening before nursing home care is authorized can divert eligible Medi-Cal beneficiaries to less expensive community-based long-term care services. Moreover, the Legislature has urged that public agencies emphasize reliance on community-based services that enable beneficiaries to continue residing in the community. In California, two Medi-Cal field offices of the Department of Health Services (department) have implemented pre-admission screening. The San Jose office diverted 58 (21.2 percent) of the 273 Medi-Cal beneficiaries screened to community-based long-term care services in fiscal year 1982-83. Records on 37 of the 58 beneficiaries show that pre-admission screening saved the State $45,400 in Medi-Cal funds. If the San Jose office had screened all beneficiaries living in the community who sought admission to nursing homes that year, the net savings to the State from this office alone would have been approximately $113,000.

## Recent Legislation Has Emphasized Community-Based Long-Term Care

The Legislature has adopted several measures that endorse providing long-term care in a community setting. Most recently, the Legislature enacted Chapter 1453, Statutes of 1982, which emphasizes providing long-term care services that allow beneficiaries to remain an integral part of family and community life to the fullest extent possible.

In this legislation, the Legislature intended that public agencies avoid inappropriate placement of beneficiaries in nursing homes, emphasizing instead self-reliance and independent living in the community. This legislation also created the Long-Term Care Advisory Task Force (authorized in Section 16369.1 of the California Government Code) to report to the Legislature and to assist with implementing the legislation.

## Community-Based Long-Term Care Saves Money and Promotes Independent Living

Recent studies indicate that providing long-term care in a community setting saves public funds and is beneficial to the elderly. For example, a 1983 study by the department compared the monthly cost of providing nursing home care with the costs for providing adult day health care and any additional Medi-Cal assistance, SSI/SSP payments, and IHSS grants that beneficiaries receiving adult day health care require. The

study showed that the total monthly cost of providing adult day health care is less than the cost of providing care in nursing homes. Using the data in this study, we estimate that providing adult day health care in combination with other community-based long-term care services generated an annual savings of $3,175 per Medi-Cal beneficiary. The federal share of these savings was $1,504 with the State's share $1,671.

A 1983 report by the California Health and Welfare Agency also indicated that savings of public monies result when beneficiaries who are at risk of entering nursing homes receive community-based long-term care services instead. This report concerns the Multipurpose Senior Services Project, which assesses Medi-Cal beneficiaries' need for long-term care services, develops a plan for providing them, and monitors the delivery of these services. Based on the data in this report, we estimate that the average annual savings for each beneficiary who uses community-based services amounted to $2,710, of which the federal share was $1,192 and the State's share $1,518.

Studies also indicate that Medi-Cal beneficiaries who rely on community-based long-term care services generally experience a better quality of life than they would experience in nursing homes. A 1982 study by the U.S. Department of Health and Human Services' Health Care Financing Administration reported that nursing homes are typically large institutions characterized by social deprivation, regimentation, and a lack of privacy. The study concluded that placing a beneficiary in a nursing home creates dependency, which in turn reduces the beneficiary's will and capacity to live in the community.

## Pre-Admission Screening Is Preferable to Post-Admission Review

Increases in the cost of providing nursing home care for the elderly have created an incentive for states to adopt programs that reduce their expenditures for the federal Medical Assistance Program (Medicaid). One program implemented by 18 states is comprehensive pre-admission screening for Medicaid beneficiaries who request admission into nursing homes.

Implementation of pre-admission screening in these states varies. All 18 states require that nursing homes obtain state authorization for treating Medicaid beneficiaries prior to requesting reimbursement for services. In addition, most states mandate that nursing homes notify the responsible government agency whenever a Medicaid beneficiary who is living in the community requests admission to a nursing home. Some states also require such notification for persons in acute care hospitals who request admission to nursing homes.

Pre-admission screening, as practiced by these other states, is preferable to California's post-admission review process in several respects: timing of the review, use of multidisciplinary teams, comprehensive assessments of beneficiaries' needs, and reliance on community-based long-term care services. Other states also report that pre-admission screening reduces the cost of providing long-term care.

Timing of Review

Pre-admission screening affords more opportunity than that provided by post-admission review for keeping elderly Medi-Cal beneficiaries out of nursing homes. This conclusion is supported by a 1979 Rand Corporation study, which determined that the ideal time to make decisions on the appropriateness of nursing home care is prior to admission.

Preventing admission to a nursing home is advantageous. According to the California Health and Welfare Agency's "State Plan for Long-Term Care," because nursing homes limit a person's participation in self-care, his or her self-help skills may deteriorate rapidly, and the person may lose touch with reality. Thus, after elderly persons have been admitted to a nursing home, their condition may deteriorate to the point that they cannot be discharged.

Being discharged from a nursing home by the post-admission review process may also cause problems for the beneficiary. According to the Health Care Financing Administration's 1982 study, many elderly persons simply cannot withstand the trauma of another relocation to a different environment. Furthermore, this same study points out that many elderly persons who enter a nursing home may no longer have homes or apartments to which they may return.

## Use of Multidisciplinary Teams To Conduct Comprehensive Assessments

Most states that have implemented pre-admission screening use multidisciplinary teams. These teams usually consist of a nurse and a social worker, and in some states a physician as well. In 15 of the states that conduct pre-admission screening, a social worker is involved in assessing all requests for nursing home care. By contrast, current on-site review procedures in California limit the involvement that social services consultants have with Medi-Cal beneficiaries admitted to nursing homes. Medi-Cal nurse consultants conduct the on-site reviews. For nursing homes that are subject to the on-site review process, social services consultants investigate only those beneficiaries that nurse consultants, nursing home operators, patients, or other individuals believe are receiving a higher level of care than is appropriate for their medical conditions. In three of the Medi-Cal field offices that we visited, social services consultants were requested to review only 2 percent of the admissions to nursing homes.

Multidisciplinary teams in other states conduct comprehensive assessments of each individual's needs and may evaluate the physical, psychological, and social aspects of the person's condition. For example, the South Carolina Community Long Term Care Project uses forms that gather information on each individual's psycho-social functioning and family support system. Psycho-social functioning includes a person's emotional strength and motivation, the person's response to illness, and any traumas that the person has experienced. A person's family support

system includes family members who may be able to assist with some of a person's long-term care needs. Similarly, Massachusetts' Case Management Screening Program uses forms that document not only the individual's social history and family support system, but also whether community-based long-term care services have been considered before requesting nursing home care. Multidisciplinary teams in these states use this information to develop a plan of care that emphasizes the use of community-based long-term care services whenever possible.

In contrast, California's policy for reviewing the need for long-term care focuses primarily on the beneficiary's medical condition and gives little consideration to the beneficiary's social needs. The Medi-Cal field offices do not use forms that are specifically designed to gather any information on the beneficiary's psycho-social functioning or family support system. Furthermore, the criteria in California's Medi-Cal regulations for authorizing the level of care do not require that staff consider community-based long-term care services before authorizing admission to a nursing home. As a result, the department's system for approving requests for long-term care does not emphasize the substitution of lower-cost community-based long-term care services for nursing home care.

Reliance on Community-Based
Long-Term Care

Pre-admission screening programs in other states have diverted from nursing home care a substantial number of elderly Medicaid beneficiaries by emphasizing the use of community-based long-term care services. The Virginia Nursing Home Pre-Admission Screening Program, implemented on a full-scale basis following a one-year pilot study, has diverted to community-based long-term care services approximately 14 percent of the beneficiaries that were screened during federal fiscal year 1982-83.

Massachusetts' Case Management Screening Program denied 8.7 percent of the requests for nursing home care that it received during fiscal year 1982-83 and diverted 57 percent of these beneficiaries to community-based long-term care services instead. Finally, the South Carolina Community Long Term Care Project realized a diversion rate of 17 percent by substituting community-based long-term care services for nursing home care.

Reduced Cost

Pre-admission screening reduces total public assistance expenditures for long-term care by diverting beneficiaries who are eligible for nursing home care to less costly community-based long-term care services. Virginia's Department of Health estimates that its pre-admission screening program produced during federal fiscal year

1982-83 a potential "cost avoidance" to the state that could be as great as $4.2 million. This figure does not account for any costs associated with community-based long-term care services provided to beneficiaries.

Massachusetts' Department of Public Welfare reported a "cost avoidance" savings of $1.2 million during fiscal year 1982-83 as a result of its Case Management Screening Program. This savings does take into account costs associated with community-based long-term care services. Likewise, South Carolina's Department of Social Services estimates that the South Carolina Community Long Term Care Project saved $141,000 in three counties during an 18-month period by substituting community-based long-term care services for nursing home care.

## Pre-Admission Screening Is Practiced in Two California Medi-Cal Field Offices

In response to the department's authorization for Medi-Cal field offices to use pre-admission screening, two field offices--San Jose and San Diego--now use pre-admission screening.

### San Jose

The San Jose field office initiated a pre-admission screening program in January 1982. Nursing homes that choose to participate contact the office's social services consultant whenever a beneficiary

who resides in the community seeks admission. The consultant reviews the case and attempts to divert beneficiaries to community-based long-term care services that meet their needs. During fiscal year 1982-83, the San Jose social services consultant diverted 58 (21.2 percent) of the 273 beneficiaries screened.

Diverting Medi-Cal beneficiaries to community-based long-term care services saved money for both the state government and the federal government. Although we were unable to calculate the savings for 21 of the 58 beneficiaries because we could not obtain necessary identifying information, we determined that the community-based services provided to 37 of the beneficiaries for various periods during fiscal year 1982-83 cost $130,300. We estimated that providing care for them in nursing homes would have cost $203,600. Thus, we estimate that these diversions generated $73,300 in savings, with the State's share $45,400 and the federal share $27,900.* The average savings per beneficiary was $1,980, of which the State's share was $1,227 and the federal share $753. (The Appendix contains a detailed comparison of the costs of long-term care for these 37 beneficiaries.)

*The federal share of savings that we show here may not include all Medicare expenditures associated with these cases. We obtained Medicare charges from the Medi-Cal Claim Detail Reports, which do not necessarily report all Medicare charges. We were unable to obtain a complete listing of Medicare charges from the U.S. Department of Health and Human Services within the period allotted to complete this audit.

These figures do not represent savings over the entire fiscal year because all of the beneficiaries had been using the community-based long-term care services for less than one year. Had all beneficiaries been using community-based services during the entire fiscal year, the savings would have been larger. At the end of fiscal year 1982-83, 22 of the 37 beneficiaries that we studied were still using community-based long-term care services.

The nursing homes that participate in pre-admission screening in the San Jose area do so on a voluntary basis. We estimate that the social services consultant in the San Jose field office received referrals on only 59 percent of the cases in which beneficiaries living in the community requested admission to nursing homes. According to the social services consultant at the San Jose field office, most of the beneficiaries who were diverted to community-based long-term care services would be considered "light-care patients," patients who do not require a great deal of skilled nursing care. In 1983, the U.S. General Accounting Office reported that because occupancy rates in nursing homes are high, nursing homes can be selective in their admissions, and in fact, they prefer to admit light-care Medicaid patients. Since light-care Medi-Cal beneficiaries are also most likely to be eligible for community-based long-term care services, it follows that unless pre-admission screening becomes mandatory, nursing homes will admit Medi-Cal beneficiaries who could be diverted to community-based long-term care services at a lower cost to the State.

If pre-admission screening became mandatory for all beneficiaries seeking to move from the community into nursing homes, the San Jose social services consultant stated that he would need the assistance of an additional half-time social services consultant and a half-time medical records technician. The annual cost to the State for these additional positions during fiscal year 1982-83 would have been approximately $7,200. Assuming that the same diversion rate of 21.2 percent would apply to the additional referrals produced by mandatory pre-admission screening, we estimate that even with the cost of the additional staff the total net savings to the State from mandatory pre-admission screening would have been approximately $113,000 in the San Jose office alone.

San Diego

The San Diego Medi-Cal field office has also implemented a pre-admission screening program for beneficiaries living in the community who request admission to nursing homes. To qualify for Medi-Cal reimbursement, all nursing homes in the San Diego area must obtain authorization for treatment from the field office prior to admitting beneficiaries residing in the community. Either the social services consultant or the supervising nurse consultant screens all requests for treatment. The supervising nurse authorizes nursing home care for a beneficiary who is unable to control his or her bowels and bladder, who falls frequently, or who cannot get out of bed. She refers all other cases to the social services consultant for possible diversion to community-based long-term care services.

The San Diego field office does not have any data on the results of its pre-admission screening program. The staff have not differentiated pre-admission screening requests from other types of referrals that the social services consultant receives. In response to our request for information, the field office has now implemented a recordkeeping system that will provide data on its program.

## Department Difficulties in Implementing Pre-Admission Screening Can Be Overcome

The chief of the Field Services Branch in the department's Medi-Cal Division and the administrators of the Medi-Cal field offices told us that the department has not implemented pre-admission screening in all Medi-Cal field offices because the offices lack staff, the State lacks sufficient community-based long-term care services, two offices tested the program and concluded that it was not successful, and finally, the on-site review process conducted at the nursing homes prevents inappropriate placement. We have evaluated all these reasons and concluded that although some of these problems may limit the effectiveness of pre-admission screening in some offices, they should not preclude testing the program in all offices.

Staffing Shortage

The chief of the Field Services Branch said that field offices do not have staff available for pre-admission screening of requests for nursing home care. The chief stated that because social services consultants do not have enough time to implement all worthwhile activities, those activities that are the most cost-effective should receive the highest priority. He pointed out, for example, that social services consultants' arranging in-home nursing care for 61 people statewide, who would otherwise be in acute care hospitals, generated $505,000 in savings per month. In addition, reviews of requests for transportation in the San Diego field office generated an estimated $350,000 in savings over a 15-month period. The San Diego field office administrator also stated that more intensive reviews of requests for durable medical equipment, such as oxygen and wheelchairs, would generate additional savings.

Although the chief provided estimates of savings, he could not provide estimates of the costs associated with these various programs. Consequently, we were unable to determine how cost-effective these programs were. Nonetheless, the chief believes that these activities should receive priority over pre-admission screening, given the finite amount of time that social service consultants have available.

We found, however, that implementing pre-admission screening would not necessarily prevent field offices from conducting other cost-effective activities. The administrator of the San Jose field office told us that the social services consultant in the San Jose office conducts pre-admission screening without sacrificing other responsibilities. In addition, the administrator of the San Diego field office said that medical technicians and clerks can review requests for purchases of durable medical equipment and for transportation.

The chief of the Field Services Branch also indicated that a current disagreement between the department and Region IX of the U.S. Department of Health and Human Services' Health Care Financing Administration could have a significant effect on workloads of social services consultants. In July 1983, the federal government determined that the State's procedures for on-site review of long-term care do not meet the federal requirement that the medical records of each Medi-Cal beneficiary in a nursing home be reviewed annually. The federal government has recommended that the department's inspection teams, each consisting of a physician or registered nurse and a social services consultant, assume this responsibility. The chief of the Field Services Branch said that the changes suggested by the federal government would create a significant amount of work for social services consultants, leaving no time for pre-admission screening.

Our analysis, however, indicates that the State could comply with the federal government's requirement without increasing the workload of social services consultants; Medi-Cal nurse consultants could perform the required review of medical records while at nursing homes conducting on-site reviews. A representative from the Region IX Health Care Financing Administration office told us that this solution would be acceptable to the federal government.

Administrators of four of the field offices also expressed the view that current staff is not sufficient to permit pre-admission screening. However, the department has recently obtained an exemption from the state hiring freeze that will increase the number of social services consultants assigned to these four Medi-Cal field offices. The San Bernardino and Santa Barbara field offices will each receive one full-time social services consultant, and the Sacramento field office, which currently shares one full-time social services consultant position with the Redding field office, will receive an additional half-time social services consultant. The administrator of the Santa Barbara field office stated that the office should be able to implement pre-admission screening once the new position is filled. However, the administrators of the Sacramento, Redding, and San Bernardino field offices told us that they would need even further additions to their staff to implement pre-admission screening.

The experience of the San Jose and San Diego field offices indicates that offices could probably handle some of the pre-admission screening workload without additional staff and without sacrificing any of the offices' regular responsibilities. However, some field offices, including San Jose, may need additional staff if pre-admission screening becomes mandatory.

We used the experience of the San Jose field office to estimate the additional staff that the State would need to implement mandatory pre-admission screening. We estimate that a mandatory pre-admission screening program in San Jose would have yielded 460 requests for screening during fiscal year 1982-83. The social services consultant in the San Jose field office told us that to process 460 requests for pre-admission screening, he would need the assistance of one half-time medical technician and one half-time social services consultant in addition to one-third of his own time. These figures produce a ratio of five-sixths of a social services consultant position (one-half plus one-third) and one-half of a medical technician position per 460 requests. We estimate that a mandatory statewide pre-admission screening program would generate a workload of approximately 6,700 cases. Thus, pre-admission screening could be implemented in all offices with the addition of 12 social services consultants and 7 medical technicians.

The cost of these additional positions would be offset by the savings resulting from greater use of community-based long-term care services. We estimate that if the Los Angeles field office reproduced the 10.8 percent diversion rate it experienced during its one-year experiment with pre-admission screening, the cost savings generated by the Los Angeles office alone would exceed the cost for the additional positions for all the Medi-Cal field offices.

As a final note, however, even though statewide cost savings resulting from mandatory pre-admission screening should greatly exceed the cost of additional staff, we maintain that the department should request additional staff only for those field offices that can demonstrate with workload data that they cannot implement pre-admission screening with existing resources.

## Lack of Community-Based Long-Term Care Services

Another objection to pre-admission screening raised by the chief of the Field Services Branch and the administrators in five field offices is that the State does not have enough community-based long-term care services to make pre-admission screening feasible. Although we have not conducted a comprehensive inventory of community-based long-term care services throughout the State, our research does indicate that the San Jose and San Diego field offices have not experienced a shortage in community-based long-term care services. Furthermore, every part of the State has access to Medi-Cal assistance, SSI/SSP assistance,

and the In-Home Supportive Services Program. In addition, almost all parts of the State have access to home health care. Finally, some parts of the State have an ample number of residential care facilities and adult day health care centers.

Possibly, some field offices may find that community-based long-term care services in their areas are not sufficient to serve all beneficiaries that could be diverted to them. Although this problem may limit the number of diversions in some areas, it should not prohibit implementing pre-admission screening. Field offices that cannot divert all eligible beneficiaries because of a shortage of community-based long-term care services in their areas should use this data to document the extent to which the services are insufficient.

## Pre-Admission Screening Unsuccessful in Two Field Offices

From February through August 1983, the Medi-Cal field office in Oakland conducted a test of pre-admission screening. Based on the test, the staff concluded that pre-admission screening was not successful. Field office staff limited their test to 12 of the 118 nursing homes located within the office's jurisdiction. These nursing homes were not required to refer to the office all requests for admission from Medi-Cal beneficiaries living in the community. After six months, the staff terminated the program because they felt it was not cost-effective. During this period, the social services consultant had diverted only 3 (8 percent) of the 39 beneficiaries that the nursing homes referred to

him. In our opinion, however, the small number of nursing homes included in the test make the results of the Oakland experiment inconclusive.

The Los Angeles field office initiated pre-admission screening in July 1982 and diverted 10.8 percent of the 139 beneficiaries screened. The referrals from nursing homes were voluntary. The office discontinued the program after one year because field office staff felt that they had not diverted enough beneficiaries to make the effort cost-effective.

However, data collected by the Los Angeles field office indicate that nursing homes referred to the social services consultants only 139 cases, representing 0.4 percent of the 34,341 requests for nursing home care that the Los Angeles field office received from July 1982 to June 1983. This figure is significantly less than the 273 cases that nursing homes referred to the San Jose office for pre-admission screening; those 273 cases represented 5.7 percent of the 4,757 requests for nursing home care that the San Jose field office received during the same fiscal year. Since the number of referrals received by the Los Angeles field office represents such a relatively small percentage of requests for admission to the nursing homes within its jurisdiction, we conclude that the results of this pre-admission screening test in Los Angeles are also inconclusive.

## On-Site Review at Nursing Homes Prevents Inappropriate Placements

Field office administrators in five field offices told us that pre-admission screening is not needed. They feel that the on-site review process combined with the experience of the staff at the nursing homes already ensures that beneficiaries receive the lowest appropriate level of long-term care. To test this claim and to determine whether any beneficiaries approved for nursing home care could have been served by community-based long-term care services instead, we reviewed files for nursing home residents in six Medi-Cal field offices. The supervising nurse consultant at the San Jose field office provided us with criteria for determining whether a beneficiary could possibly be moved to long-term care in the community. According to these criteria, a person does not need to be in a nursing home if the person is fairly independent in the activities of daily living, is not too confused, and has sufficient control of bowels and bladder.

We identified 12 beneficiaries who we considered capable of being served by community-based long-term care services. The supervising nurse consultant and social services consultant at the offices that we visited agreed with our assessments. Because the information in the Medi-Cal files is limited to the beneficiaries' medical conditions, we were not able to identify all cases where beneficiaries resided in nursing homes but did not require that level of care. As pre-admission screening programs in other states have demonstrated, assessing whether a beneficiary's long-term care needs can

be met with community-based long-term care services requires information on the beneficiary's psycho-social functioning and family support system. This type of information is not available in California's Medi-Cal files. However, the cases that we were able to identify demonstrate that the department's on-site review process is admitting to nursing homes some Medi-Cal beneficiaries who could be served by community-based long-term care services.

## CONCLUSION

Studies indicate that pre-admission screening of requests for admission to nursing homes from Medi-Cal beneficiaries living in the community is more effective than post-admission reviews for ensuring that beneficiaries receive the lowest appropriate level of long-term care. Pre-admission screening enables elderly beneficiaries to remain independent by substituting community-based long-term care services for nursing home care. Pre-admission screening in the San Jose Medi-Cal field office saved the State $45,400 during fiscal year 1982-83 and could have saved the State $113,000 if pre-admission screening had been mandatory. Other states' pre-admission screening programs have produced similar benefits. The Department of Health Services states that for several reasons it cannot implement pre-admission screening statewide. We evaluated these reasons and concluded that although these problems may limit the effectiveness of pre-admission screening in several offices, they should not preclude testing the program in all offices.

## RECOMMENDATIONS

To ensure that Medi-Cal beneficiaries receive the lowest appropriate level of long-term care, the Department of Health Services should do the following:

- Revise Medi-Cal regulations and forms for authorizing and evaluating admissions to nursing homes of beneficiaries living in the community so that field office staff collect information about each beneficiary's family support system. Field office staff should consider this data when determining the lowest appropriate level of care for Medi-Cal beneficiaries.

- Instruct each field office to estimate the number of cases that would require pre-admission screening and to assess thoroughly the extent to which existing staff could assume any of that workload. Using the staffing ratios developed by the San Jose field office and the availability of existing staff, each office should determine if it needs additional staff to implement pre-admission screening fully. The department should request additional staff only for those offices that demonstrate with workload data that they cannot fully implement pre-admission screening with existing staff. Based on the data in this report, the department should assess the cost-effectiveness of

pre-admission screening. No office should receive additional staff if it has staff assigned to activities that are not mandated by the federal government and that are less cost-effective than pre-admission screening. Any additional positions should be authorized on a limited basis with the authorization expiring at the conclusion of the period for testing and evaluating pre-admission screening. Because pre-admission screening will produce a net savings in Medi-Cal expenditures, the department should reduce its budget for Medi-Cal long-term care services by the amount it requests for staff augmentation.

- Conduct training sessions for all social services consultants and medical technicians who will be involved in pre-admission screening. Social services consultants who have already implemented pre-admission screening should teach these training sessions.

- Implement pre-admission screening in all field offices and evaluate the effectiveness of pre-admission screening after one year. Pre-admission screening should be considered cost-effective in those offices in which state expenditures for beneficiaries diverted to community-based long-term care are less than the cost of care at skilled nursing facilities combined with the cost incurred by the field office for administering the program. After

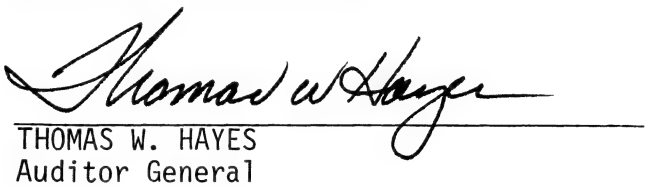
completing this evaluation, pre-admission screening should continue only in those offices where it has been cost-effective. Any additional staff hired should be retained only in offices where pre-admission screening has been cost-effective.

- Require all nursing homes to refer to the Medi-Cal field offices for pre-admission screening all cases involving Medi-Cal beneficiaries living in the community who are requesting admission to nursing homes. After the one-year evaluation, this requirement would remain in effect only for those nursing homes regulated by Medi-Cal field offices that have cost-effective pre-admission screening programs.

- Direct the Medi-Cal field offices to document cases in which beneficiaries have been placed at an inappropriately high level of care because of insufficient community-based long-term care services. The department should use this data to report the extent of the shortage of community-based long-term care services to the entity responsible for planning community-based long-term care services in this State. The Legislature is to designate this entity after receiving the report of the Long-Term Care Advisory Task Force.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: March 26, 1984

Staff: Steven L. Schutte, Manager
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**GEORGE DEUKMEJIAN**, *Governor* STATE OF CALIFORNIA

HEALTH and WELFARE AGENCY
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March 19, 1984

Mr. Thomas W. Hayes
Auditor General
Office of the Auditor General
600 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

I am pleased to respond to your draft report entitled "Pre-Admission Screening Reduces the Cost of Providing Long-Term Care to Elderly Medi-Cal Beneficiaries and Promotes Independent Living." Overall, we support the findings and recommendations in the report.

The findings regarding the desirability of pre-admission screening for individuals entering nursing homes from a residential care setting are consistent with the findings made by the Department of Health Services in their recently completed study in response to SB 1678. We expect to release that report to the legislature within the next few weeks and will make a copy available to your office at your request.

We agree with the principle that pre-screening affords not only the opportunity to maintain individuals in a home or community-based setting but affords potential savings in expenditures for institutional care as well. To this end, the Agency is working to design an effective intercept program for persons entering nursing homes. As you are aware, AB 2860 addressed this same concept but was determined to be too expensive to implement. We are now looking at alternatives and will be recommending a more cost effective approach later this year.

The major area where we have concern with respect to the recommendations in the report that pre-screening be tested on a statewide basis, is the availability of resources to do so. During the past year, we have looked very closely at all programs in the Department of Health Services to assure that only positions necessary to carry out mandated and highly essential or cost-effective activities are found in the Department.

The Field Services Branch, which would be responsible for conducting the recommended pre-screening study, is responsible for a number of the federally mandated and highly cost-effective utilization review activities. Overall, the utilization review activities performed by this Branch have a cost effectiveness of approximately 1:6 with some activities (such as acute on-site hospital utilization review) having a cost effectiveness as high as 1:13.

The data contained in your report suggest that the cost-effectiveness for the recommended pre-screening program will be approximately 1:6.

Certainly, cost benefit should not be the only consideration in determing the relative importance of conducting the pre-screening program since it does afford the opportunity to maintain individuals in the community rather than to place them in an institutional setting. Within its discretionary staff time, (staff time available for other than performing mandated workload) Field Services Branch has been engaged in what they consider an equally valuable and important activity of developing cases for in-home nursing care for individuals who would otherwise remain in an acute hospital setting indefinitely. This activity has proven to be not only highly cost-effective, but extremely beneficial to the individuals for whom we are able to obtain nursing care in their home and transfer them from an almost otherwise permanent home in an acute hospital.

There are currently 90 cases of individuals for whom in-home nursing care has been arranged and it is not unusual for the cost savings for a single case to be $100,000 a year. When contrasted with the savings of $113,000 a year estimated in your report for a pre-screening program in a single field office (as opposed to a single case), I am sure you will appreciate that the in-home nursing care program should continue to receive a high priority in terms of the allocation of discretionary staff resources.

We propose to take several steps to implement the recommendations in your report for a statewide test of pre-screening patients proposed for placement into nursing homes from home or a community care setting. First, we will ask each field office to identify staff resources currently allocated to mandatory and discretionary utilization review activities. Those field offices that have adequate staff resources to commence the pre-screening program will be asked to do so. For field offices that are found not to have the staff resources to commence the pre-screening program, we will be unable to implement pre-screening until a thorough review of competing priorities has been completed and a decision is made regarding the allocation of scarce resources to competing priorities. (*)

Thank you for preparing this study for us and for pointing out the potential benefits of pre-nursing home admission screening.

Sincerely,

for DAVID B. SWOAP
Secretary

(*) Auditor General Comment: Scarcity of staff resources should not be a limiting factor in implementing pre-admission screening. Our report documents substantial cost savings and social benefits attributable to pre-admission screening. On page 26 of our report, we estimate that the cost savings that pre-admission screening would generate in the Los Angeles field office alone would more than pay for the cost of additional staff needed to implement the program statewide. As a result, we have recommended that the department test mandatory pre-admission screening in all of its Medi-Cal field offices for one year, even if the department must hire additional staff.

# COST SAVINGS FROM PRE-ADMISSION SCREENING OF MEDI-CAL BENEFICIARIES IN THE SAN JOSE MEDI-CAL FIELD OFFICE

In this appendix, we explain the method by which we computed savings resulting from the use of pre-admission screening by the San Jose Medi-Cal field office. The three tables at the end of the appendix show the figures used in our computations.

Table 1 illustrates the combined effect on state and federal expenditures of pre-admission screening in the San Jose Medi-Cal field office. The first two columns indicate the case number we assigned to the beneficiary and the number of months each beneficiary was diverted from nursing home care during fiscal year 1982-83 as a result of pre-admission screening. We determined the length of each diversion in the following manner. For beneficiaries who had been granted short stays of less than four months in nursing homes as a result of pre-admission screening, the diversion period began on the date the beneficiary left the nursing home and ended with either the date the beneficiary died or was readmitted into a nursing home, or the end of the fiscal year, whichever occurred first. In the remaining cases, the diversion period began on the date pre-admission screening occurred and ended with either the date the beneficiary died or was admitted into a nursing home, or the end of the fiscal year. Finally, for cases in which the beneficiary entered an acute care hospital and never returned to the community, the diversion period ended with the date the beneficiary entered the hospital.

Columns 3 through 7 of Table 1 reflect the specific costs associated with maintaining these beneficiaries in the community. Medicare and Medi-Cal charges represent the cost of health-related services, SSI and SSP costs represent the amount of income maintenance provided by the Supplemental Security Income/State Supplementary Program, and IHSS costs represent the amount of personal care and household chore services received by these beneficiaries from the In-Home Supportive Services Program. The total amount of public money spent to maintain these beneficiaries in the community is shown in column 8.

Columns 9, 10, and 11 of Table 1 represent estimates of the amount of money the Medicare and Medi-Cal programs would have spent for care for these beneficiaries in skilled nursing facilities and for other related services, including hospital inpatient care, professional services, and pharmaceuticals, if these beneficiaries had not been diverted to community-based long-term care services. We estimate that the Medi-Cal program would have spent $979 per month, and that the Medicare program would have spent $389 per month if these beneficiaries had received nursing home care and other related services. The estimate for the Medi-Cal program is based on the average monthly cost to Medi-Cal for services used by nursing home residents during fiscal year 1982-83.

The estimate for the Medicare program is based on the estimated average monthly cost to Medicare for services used by nursing home residents during 1983.

Finally, column 12 of Table 1 shows the estimated net savings or loss for both the state government and the federal government attributable to pre-admission screening. This net figure is calculated by subtracting the total cost of maintaining beneficiaries in the community (column 8) from the estimated cost of nursing home care (column 11).

Table 2 shows the effect of pre-admission screening on the State's share of expenditures for the beneficiaries diverted to community-based long-term care services. The first two columns indicate the case number assigned to the beneficiary and the number of months the beneficiary was diverted from nursing home care during fiscal year 1982-83 as a result of pre-admission screening. Columns 3 through 5 reflect the State's share of the specific costs associated with maintaining these beneficiaries in the community. The total amount of state money spent to maintain these beneficiaries in the community is shown in column 6. Column 7 represents an estimate of the amount of money the State would have spent for care in skilled nursing facilities if these beneficiaries had not been diverted to community-based long-term care services. Finally, column 8 shows the estimated net savings or loss for the State attributable to pre-admission screening. This figure is calculated by subtracting the total state cost of maintaining beneficiaries in the community (column 6) from the estimated state cost for nursing home care (column 7).

Table 3 shows the effect of pre-admission screening on the federal share of expenditures for beneficiaries diverted to community-based long-term care services. The first two columns indicate the case number assigned to the beneficiary and the number of months the beneficiary was diverted from nursing home care during fiscal year 1982-83 as a result of pre-admission screening. Columns 3 through 7 reflect the federal government's share of the specific costs associated with maintaining these beneficiaries in the community. The total amount of federal money expended to maintain these beneficiaries in the community is shown in column 8. Columns 9 and 10 show estimates of the amount of money the federal government would have spent for nursing home care if these beneficiaries had not been diverted to community-based long-term care services. Finally, column 12 represents the estimated net savings or loss for the federal government attributable to pre-admission screening. This figure is calculated by subtracting the total cost to the federal government for maintaining beneficiaries in the community (column 8) from the estimated cost to the federal government for nursing home care (column 11).

## TABLE 1

### COMBINED SAVINGS ATTRIBUTABLE TO PRE-ADMISSION SCREENING DURING FISCAL YEAR 1982-83

| | | Cost of Community-Based Services | | | | | | Estimated Cost of Care in Skilled Nursing Facilities | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Case Number | Months Diverted | Medicare Charges | Medi-Cal Charges | SSI Cost | SSP Cost | IHSS Cost | Total Cost | Medicare Cost | Medi-Cal Cost | Total Cost (9 + 10) | Estimated Savings (11 - 8) |
| 1 | 0.7 | $ 0 | $ 81 | $ 0 | $ 0 | $ 0 | $ 81 | $ 272 | $ 685 | $ 957 | $ 876 |
| 2 | 5.0 | 482 | 129 | 0 | 432 | 31 | 1,074 | 1,946 | 4,896 | 6,842 | 5,768 |
| 3 | 4.5 | 772 | 22 | 0 | 0 | 0 | 794 | 1,752 | 4,406 | 6,158 | 5,364 |
| 4 | 10.9 | 7,587 | 773 | 621 | 1,800 | 6,655 | 17,436 | 4,243 | 10,673 | 14,916 | (2,520) |
| 5 | 3.0 | 1,596 | 424 | 4 | 650 | 517 | 3,191 | 1,168 | 2,937 | 4,105 | 914 |
| 6 | 1.1 | 3,880 | 304 | 0 | 225 | 0 | 4,409 | 428 | 1,077 | 1,505 | (2,904) |
| 7 | 1.4 | 301 | 72 | 389 | 228 | 400 | 1,390 | 545 | 1,371 | 1,916 | 526 |
| 8 | 0.9 | 0 | 71 | 0 | 129 | 0 | 200 | 350 | 881 | 1,231 | 1,031 |
| 9 | 1.0 | 464 | 144 | 0 | 83 | 0 | 691 | 389 | 979 | 1,368 | 677 |
| 10 | 6.3 | 0 | 95 | 0 | 906 | 0 | 1,001 | 2,452 | 6,169 | 8,621 | 7,620 |
| 11 | 0.7 | 425 | 120 | 1 | 104 | 144 | 794 | 272 | 685 | 957 | 163 |
| 12 | 3.6 | 210 | 53 | 0 | 293 | 0 | 566 | 1,401 | 3,525 | 4,926 | 4,370 |
| 13 | 8.6 | 996 | 765 | 0 | 1,504 | 0 | 3,265 | 3,348 | 8,421 | 11,769 | 8,504 |
| 14 | 0.5 | 219 | 79 | 455 | 361 | 0 | 1,114 | 194 | 490 | 684 | (430) |
| 15 | 1.1 | 0 | 1,265 | 215 | 189 | 444 | 2,114 | 0 | 1,077 | 1,077 | (1,037) |
| 16 | 2.6 | 913 | 428 | 571 | 428 | 0 | 2,340 | 1,012 | 2,546 | 3,558 | 1,218 |
| 17 | 6.1 | 0 | 100 | 0 | 923 | 1,492 | 2,515 | 2,375 | 5,973 | 8,348 | 5,833 |
| 18 | 5.1 | 0 | 94 | 0 | 659 | 0 | 753 | 1,985 | 4,994 | 6,979 | 6,226 |
| 19 | 11.3 | 36 | 75 | 0 | 592 | 0 | 703 | 4,399 | 11,065 | 15,464 | 14,761 |
| 20 | 2.7 | 0 | 78 | 177 | 472 | 817 | 1,544 | 1,051 | 2,644 | 3,695 | 2,151 |
| 21 | 4.4 | 0 | 23 | 0 | 0 | 198 | 221 | 1,713 | 4,308 | 6,021 | 5,800 |
| 22 | 0.8 | 0 | 6 | 156 | 151 | 15 | 328 | 311 | 783 | 1,094 | 766 |
| 23 | 6.7 | 0 | 114 | 0 | 1,203 | 703 | 2,020 | 2,608 | 6,561 | 9,169 | 7,149 |
| 24 | 5.4 | 287 | 572 | 542 | 884 | 3,966 | 6,251 | 2,102 | 5,288 | 7,390 | 1,139 |
| 25 | 7.4 | 7,757 | 795 | 23 | 1,111 | 0 | 9,686 | 2,881 | 7,246 | 10,127 | 441 |
| 26 | 1.2 | 45 | 97 | 0 | 53 | 0 | 195 | 467 | 1,175 | 1,642 | 1,447 |
| 27 | 0.7 | 0 | 51 | 0 | 132 | 0 | 183 | 272 | 685 | 958 | 775 |
| 28 | 4.1 | 14,910 | 395 | 0 | 167 | 0 | 15,472 | 1,596 | 4,015 | 5,611 | (9,861) |
| 29 | 10.0 | 366 | 175 | 2,843 | 1,667 | 0 | 5,051 | 3,893 | 9,792 | 13,685 | 8,634 |
| 30 | 3.7 | 0 | 0 | 0 | 242 | 984 | 1,226 | 1,440 | 3,623 | 5,063 | 3,837 |
| 31 | 11.0 | 0 | 371 | 3,108 | 2,467 | 0 | 5,946 | 4,282 | 10,771 | 15,053 | 9,107 |
| 32 | 1.0 | 0 | 5,376 | 284 | 167 | 295 | 6,122 | 0 | 979 | 979 | (5,143) |
| 33 | 1.9 | 0 | 114 | 217 | 523 | 345 | 1,199 | 740 | 1,860 | 2,600 | 1,401 |
| 34 | 2.1 | 0 | 67 | 0 | 144 | 1,065 | 1,276 | 817 | 2,056 | 2,873 | 1,597 |
| 35 | 4.9 | 23,590 | 844 | 1,072 | 834 | 0 | 26,340 | 1,907 | 4,798 | 6,705 | (19,635) |
| 36 | 4.7 | 202 | 261 | 0 | 87 | 1,300 | 1,850 | 1,830 | 4,602 | 6,432 | 4,582 |
| 37 | 2.3 | 0 | 59 | 187 | 378 | 408 | 1,032 | 895 | 2,252 | 3,147 | 2,115 |
| Total | 149.4 | $65,038 | $14,493 | $10,865 | $20,188 | $19,779 | $130,363 | $57,337 | $146,288 | $203,625 | $73,262 |

Source

Column 2: San Jose Medi-Cal field office records in conjunction with the Department of Health Services, Medi-Cal Assistance Program, Claim Detail Reports for Fiscal Year 1982-83.

Columns 3 & 4: Department of Health Services, Medi-Cal Assistance Program, Claim Detail Reports for Fiscal Year 1982-83.

Columns 5 & 6: SSI/SSP Payment History Reports provided by the U.S. Department of Health and Human Services, Social Security Administration.

Column 7: County departments of social services for Humboldt, Monterey, Riverside, San Benito, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, and Stanislaus counties, and the Department of Social Services, Fiscal Policy and Procedures Bureau.

Column 9: Department of Health Services, Medi-Cal Services and Expenditures Month-of-Payment Report for Fiscal Year 1982-83.

Column 10: California Health and Welfare Agency, Multipurpose Senior Services Program (MSSP), Proposed Testimony on the MSSP in Response to Requests from the Assembly Committee on Human Services, January 24, 1984, p.7, Chart 2.

## TABLE 2

## STATE SAVINGS ATTRIBUTABLE TO PRE-ADMISSION SCREENING DURING FISCAL YEAR 1982-83

| | | State Cost of Community-Based Services | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Case Number | Months Diverted | Medi-Cal Charges | SSP Cost | IHSS Cost | Total Cost | Estimated Medi-Cal Cost, Care in Skilled Nursing Facilities | Estimated Savings (7 - 6) |
| 1 | 0.7 | $ 45 | $ 0 | $ 0 | $ 45 | $ 384 | $ 339 |
| 2 | 5.0 | 72 | 425 | 13 | 510 | 2,742 | 2,232 |
| 3 | 4.5 | 12 | 0 | 0 | 12 | 2,468 | 2,456 |
| 4 | 10.9 | 433 | 1,773 | 2,872 | 5,078 | 5,977 | 899 |
| 5 | 3.0 | 237 | 641 | 223 | 1,101 | 1,645 | 544 |
| 6 | 1.1 | 170 | 222 | 0 | 392 | 603 | 211 |
| 7 | 1.4 | 40 | 225 | 173 | 438 | 768 | 330 |
| 8 | 0.9 | 40 | 127 | 0 | 167 | 494 | 327 |
| 9 | 1.0 | 81 | 81 | 0 | 162 | 548 | 386 |
| 10 | 6.3 | 53 | 892 | 0 | 945 | 3,455 | 2,510 |
| 11 | 0.7 | 67 | 102 | 62 | 231 | 384 | 153 |
| 12 | 3.6 | 29 | 289 | 0 | 318 | 1,974 | 1,656 |
| 13 | 8.6 | 428 | 1,481 | 0 | 1,909 | 4,716 | 2,807 |
| 14 | 0.5 | 44 | 356 | 0 | 400 | 274 | (126) |
| 15 | 1.1 | 709 | 186 | 192 | 1,087 | 603 | (484) |
| 16 | 2.6 | 239 | 421 | 0 | 660 | 1,426 | 766 |
| 17 | 6.1 | 56 | 909 | 644 | 1,609 | 3,345 | 1,736 |
| 18 | 5.1 | 53 | 649 | 0 | 702 | 2,797 | 2,095 |
| 19 | 11.3 | 42 | 583 | 0 | 625 | 6,197 | 5,572 |
| 20 | 2.7 | 44 | 465 | 353 | 862 | 1,481 | 619 |
| 21 | 4.4 | 13 | 0 | 85 | 98 | 2,412 | 2,314 |
| 22 | 0.8 | 3 | 149 | 6 | 158 | 439 | 281 |
| 23 | 6.7 | 64 | 1,184 | 303 | 1,551 | 3,674 | 2,123 |
| 24 | 5.4 | 320 | 870 | 1,711 | 2,901 | 2,961 | 60 |
| 25 | 7.4 | 445 | 1,094 | 0 | 1,539 | 4,058 | 2,519 |
| 26 | 1.2 | 54 | 52 | 0 | 106 | 658 | 552 |
| 27 | 0.7 | 29 | 130 | 0 | 159 | 384 | 225 |
| 28 | 4.1 | 221 | 164 | 0 | 385 | 2,248 | 1,863 |
| 29 | 10.0 | 98 | 1,642 | 0 | 1,740 | 5,484 | 3,744 |
| 30 | 3.7 | 0 | 238 | 425 | 663 | 2,029 | 1,366 |
| 31 | 11.0 | 208 | 2,430 | 0 | 2,638 | 6,032 | 3,394 |
| 32 | 1.0 | 3,011 | 164 | 127 | 3,302 | 548 | (2,754) |
| 33 | 1.9 | 64 | 514 | 149 | 727 | 1,042 | 315 |
| 34 | 2.1 | 37 | 142 | 460 | 639 | 1,152 | 513 |
| 35 | 4.9 | 473 | 821 | 0 | 1,294 | 2,687 | 1,393 |
| 36 | 4.7 | 146 | 86 | 561 | 793 | 2,577 | 1,784 |
| 37 | 2.3 | 33 | 372 | 176 | 581 | 1,261 | 680 |
| Total | 149.4 | $8,113 | $19,879 | $8,535 | $36,527 | $81,927 | $45,400 |

Source

Column 2: San Jose Medi-Cal field office records in conjunction with the Department of Health Services, Medi-Cal Assistance Program, Claim Detail Reports for Fiscal Year 1982-83.

Column 3: Department of Health Services, Medi-Cal Assistance Program, Claim Detail Reports for Fiscal Year 1982-83. The State's share of the charges was 56 percent.

Column 4: SSI/SSP Payment History Reports provided by the U.S. Department of Health and Human Services, Social Security Administration. The State's share of this cost was 98.49 percent.

Column 5: County departments of social services for Humboldt, Monterey, Riverside, San Benito, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, and Stanislaus counties, and the Department of Social Services, Fiscal Policy and Procedures Bureau. The State's share of this cost was 43.15 percent.

Column 7: Department of Health Services, Medi-Cal Services and Expenditures Month-of-Payment Report for Fiscal Year 1982-83.

TABLE 3

FEDERAL SAVINGS ATTRIBUTABLE TO PRE-ADMISSION SCREENING DURING FISCAL YEAR 1982-83

| | | Federal Cost of Community-Based Services | | | | | | Estimated Federal Cost, Care in Skilled Nursing Facilities | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Case Number | Months Diverted | Medicare Charges | Medi-Cal Charges | SSI Cost | SSP Cost | IHSS Cost | Total Cost | Medicare Cost | Medi-Cal Cost | Total Cost (9 + 10) | Estimated Savings (11 - 8) |
| 1 | 0.7 | $ 0 | $ 36 | $ 0 | $ 0 | $ 0 | $ 36 | $ 272 | $ 302 | $ 574 | $ 538 |
| 2 | 5.0 | 482 | 57 | 0 | 7 | 18 | 564 | 1,946 | 2,154 | 4,101 | 3,536 |
| 3 | 4.5 | 772 | 10 | 0 | 0 | 0 | 782 | 1,752 | 1,939 | 3,691 | 2,909 |
| 4 | 10.9 | 7,587 | 340 | 621 | 27 | 3,783 | 12,358 | 4,243 | 4,696 | 8,939 | (3,419) |
| 5 | 3.0 | 1,596 | 186 | 4 | 10 | 294 | 2,090 | 1,168 | 1,292 | 2,460 | 370 |
| 6 | 1.1 | 3,880 | 134 | 0 | 3 | 0 | 4,017 | 428 | 474 | 902 | (3,115) |
| 7 | 1.4 | 301 | 32 | 389 | 3 | 227 | 952 | 545 | 603 | 1,148 | 196 |
| 8 | 0.9 | 0 | 31 | 0 | 2 | 0 | 33 | 350 | 388 | 738 | 705 |
| 9 | 1.0 | 464 | 63 | 0 | 1 | 0 | 528 | 389 | 431 | 820 | 292 |
| 10 | 6.3 | 0 | 42 | 0 | 14 | 0 | 56 | 2,452 | 2,714 | 5,166 | 5,110 |
| 11 | 0.7 | 425 | 53 | 1 | 2 | 82 | 563 | 272 | 302 | 574 | 11 |
| 12 | 3.6 | 210 | 23 | 0 | 4 | 0 | 237 | 1,401 | 1,551 | 2,952 | 2,715 |
| 13 | 8.6 | 996 | 337 | 0 | 23 | 0 | 1,356 | 3,348 | 3,705 | 7,053 | 5,697 |
| 14 | 0.5 | 219 | 35 | 455 | 5 | 0 | 714 | 194 | 215 | 409 | (305) |
| 15 | 1.1 | 0 | 557 | 215 | 3 | 252 | 1,027 | 0 | 474 | 474 | (553) |
| 16 | 2.6 | 913 | 188 | 571 | 6 | 0 | 1,678 | 1,012 | 1,120 | 2,132 | 454 |
| 17 | 6.1 | 0 | 44 | 0 | 14 | 848 | 906 | 2,375 | 2,628 | 5,003 | 4,097 |
| 18 | 5.1 | 0 | 42 | 0 | 10 | 0 | 52 | 1,985 | 2,197 | 4,182 | 4,130 |
| 19 | 11.3 | 36 | 33 | 0 | 9 | 0 | 78 | 4,399 | 4,869 | 9,268 | 9,190 |
| 20 | 2.7 | 0 | 34 | 177 | 7 | 465 | 683 | 1,051 | 1,163 | 2,214 | 1,531 |
| 21 | 4.4 | 0 | 10 | 0 | 0 | 113 | 123 | 1,713 | 1,896 | 3,609 | 3,486 |
| 22 | 0.8 | 0 | 3 | 156 | 2 | 9 | 170 | 311 | 345 | 656 | 486 |
| 23 | 6.7 | 0 | 50 | 0 | 18 | 400 | 468 | 2,608 | 2,887 | 5,495 | 5,027 |
| 24 | 5.4 | 287 | 252 | 542 | 13 | 2,255 | 3,349 | 2,102 | 2,327 | 4,429 | 1,080 |
| 25 | 7.4 | 7,757 | 350 | 23 | 17 | 0 | 8,147 | 2,881 | 3,188 | 6,069 | (2,078) |
| 26 | 1.2 | 45 | 43 | 0 | 1 | 0 | 89 | 467 | 517 | 984 | 895 |
| 27 | 0.7 | 0 | 23 | 0 | 2 | 0 | 25 | 273 | 302 | 575 | 550 |
| 28 | 4.1 | 14,910 | 174 | 0 | 3 | 0 | 15,087 | 1,596 | 1,767 | 3,363 | (11,724) |
| 29 | 10.0 | 366 | 77 | 2,843 | 25 | 0 | 3,311 | 3,893 | 4,309 | 8,202 | 4,891 |
| 30 | 3.7 | 0 | 0 | 0 | 4 | 559 | 563 | 1,440 | 1,594 | 3,034 | 2,471 |
| 31 | 11.0 | 0 | 163 | 3,108 | 37 | 0 | 3,308 | 4,282 | 4,739 | 9,021 | 5,713 |
| 32 | 1.0 | 0 | 2,366 | 284 | 3 | 168 | 2,821 | 0 | 431 | 431 | (2,390) |
| 33 | 1.9 | 0 | 50 | 217 | 8 | 196 | 471 | 740 | 819 | 1,559 | 1,088 |
| 34 | 2.1 | 0 | 29 | 0 | 2 | 605 | 636 | 817 | 905 | 1,722 | 1,086 |
| 35 | 4.9 | 23,590 | 372 | 1,072 | 13 | 0 | 25,047 | 1,907 | 2,111 | 4,018 | (21,029) |
| 36 | 4.7 | 202 | 115 | 0 | 1 | 739 | 1,057 | 1,830 | 2,025 | 3,855 | 2,798 |
| 37 | 2.3 | 0 | 26 | 187 | 6 | 232 | 451 | 895 | 991 | 1,886 | 1,435 |
| Total | 149.4 | $65,038 | $6,380 | $10,865 | $305 | $11,244 | $ 93,833 | $57,337 | $64,370 | $121,707 | $27,874 |

Source

Column 2: San Jose Medi-Cal field office records in conjunction with the Department of Health Services, Medi-Cal Assistance Program, Claim Detail Reports for Fiscal Year 1982-83.

Columns 3 & 4: Department of Health Services, Medi-Cal Assistance Program, Claim Detail Reports for Fiscal Year 1982-83. The federal government's share of Medi-Cal charges was 44 percent.

Columns 5 & 6: SSI/SSP Payment History Reports provided by the U.S. Department of Health and Human Services, Social Security Administration. The federal government's share of the cost of SSP was 1.51 percent.

Column 7: County departments of social services for Humboldt, Monterey, Riverside, San Benito, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, and Stanislaus counties, and the Department of Social Services, Fiscal Policy and Procedures Bureau. The federal government's share of this cost was 56.85 percent.

Column 9: Department of Health Services, Medi-Cal Services and Expenditures Month-of-Payment Report for Fiscal Year 1982-83.

Column 10: California Health and Welfare Agency, Multipurpose Senior Services Program (MSSP), Proposed Testimony on the MSSP in Response to Requests from the Assembly Committee on Human Services, January 24, 1984, p.7, Chart 2.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps